UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS & MEANS, SUBCOMMITTEE ON HEALTH
HEARING ON "THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE"

WRITTEN TESTIMONY SUBMITTED JOINTLY BY
CALIFORNIA HEALTH ADVOCATES,
CENTER FOR MEDICARE ADVOCACY,
AND MEDICARE RIGHTS CENTER

May 21, 2013

Introduction

Mr. Chairman and Members of the Committee:

California Health Advocates, the Center for Medicare Advocacy, Inc., and the Medicare Rights Center are all independent, non-profit organizations with extensive experience representing older adults and people with disabilities who rely on Medicare for basic health and economic security.

Our three organizations also served as consumer representatives to a subgroup of the Senior Issues Task Force (SITF) of the National Association of Insurance Commissioners (NAIC) tasked with reviewing a provision of the Affordable Care Act (ACA) relating to Medigap policies. We offer this testimony through our perspective as beneficiary advocates and members of this deliberative NAIC process that included a range of stakeholders.

In December 2012, as a result of the work of the NAIC subgroup, the NAIC strongly recommended against adding further cost-sharing to Medigap plans in a letter to the U.S. Department of Health and Human Services.[1] In short, the research conducted by the subgroup roundly rejects the basic assumption that limited cost-sharing afforded by Medigap plans leads to overutilization of health care services. The subgroup concluded:

> The proposals [to add cost-sharing to Medigap plans] focus on overutilization by beneficiaries but do not consider the potentially serious and unintended impacts for beneficiaries and the Medicare program. Namely, in response to increased costs, beneficiaries may avoid necessary services in the short-term that may result in worsening health and a need for more intensive care and higher costs to the Medicare program in the long-term. In addition, research indicates that once beneficiaries seek care, doctors and other medical providers, not patients, generally drive the number and types of services delivered to beneficiaries. Further, the proposals do not address the fact that Medicare

[1] National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

determines which services are reimbursed and therefore, by law, covered by Medigap insurance policies.[2]

The NAIC determined that increased cost-sharing in Medigap plans was likely to prohibit the use of both necessary and unnecessary health care services. Both the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) have acknowledged this same concern in reference to proposals that increase beneficiary out-of-pocket costs.[3] By way of the subgroup's conclusion, the NAIC rebuffed the notion that increased cost-sharing is an appropriate tool to limit unnecessary use of health care services.

Although this NAIC subgroup focused on potential changes to Medigap plans, the research reviewed and the resulting conclusions are applicable to a range of Medicare reform proposals, including the subject of this testimony—proposals to modify Medicare costs sharing by introducing home health copayments, increasing the Part B deductible, and further income-relating Part B and D premiums.

Our testimony focuses on how the three enumerated types of proposed cost sharing would impact the lives of people with Medicare.[4] While taking a measured look at the program outside of the context of deficit reduction would be a welcome exercise, we believe that the Medicare reform proposals which are the subject of this hearing would have harmful, unintended consequences for beneficiaries. Each of these proposals might save federal dollars in the short run, but would do so through significant cost-shifting to beneficiaries. At the same time, none of these proposals address the long-term challenge of systemic health care inflation that threatens our nation's ability to provide affordable health care, both in public and private markets.

Current Expenses and Coverage for Medicare Beneficiaries

Before considering proposals that would alter what Medicare beneficiaries pay for their health care, it is necessary to understand the current fiscal challenges faced by this population. The vast majority of Medicare beneficiaries have low or moderate incomes. In 2012, half of all Medicare beneficiaries had annual incomes below $22,500, or below 200% of the federal poverty level

[2] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

[3] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf; Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

[4] Note that our three organizations previously submitted joint testimony to this subcommittee regarding its February 26, 2013 hearing entitled "Examining Traditional Medicare's Benefit Design." This testimony is available at each of our websites, including: http://cahealthadvocates.org/_pdf/advocacy/2013/Medicare_Redesign_Testimony_CHA_CMA_MR_20022513.pdf.

(FPL).[5] Half of beneficiaries had just $77,500 in personal savings.[6]To put this in context, the average annual cost of care in a semi-private nursing room in was $130,000 in 2011. In 2010, an estimated one-third of Medicare beneficiaries have annual incomes below $16,755—150% of the FPL for a single person.[7] [8]

Contrary to general belief, Medicare beneficiaries already pay more than other groups for their health care. Medicare households have a lower average budget than the average household (about $30,800 vs. $49,600 respectively) but devote a substantially larger share of their income to medical expenses than does the average household (15% vs. 5% respectively). Two-thirds of the medical spending by Medicare households goes to premiums for Part B, Medicare Advantage, Part D, and/or supplemental coverage.[9]

Medicare beneficiaries also tend to have greater health needs than other groups. Nearly half (40%) of older adults covered by Medicare have three or more chronic conditions, and nearly one-fourth (27%) are in fair or poor health.[10] Typical out-of-pocket health spending for someone in fair or poor health without any supplemental benefits is about $4,500 per year.[11]

Because the current Medicare benefit is not overly generous and requires considerable out-of-pocket costs, approximately 90% of Medicare beneficiaries have some type of coverage that supplements Medicare. Some have retiree benefits through former employment (30%), Medicare Advantage plans (29%), Medicaid (14%) and Medigap (18%), and others who have only Medicare (8%) are also entitled to benefits through the Veteran's Administration.[12] Many of these supplemental types of insurance, in effect, limit out-of-pocket expenses. Even with these supplemental coverage options, people with Medicare lack coverage for particular services, including most long-term care services and supports and dental care.

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[5] Kaiser Family Foundation, "Policy Options to Sustain Medicare for the Future" (January 2013), available at: http://www.kff.org/medicare/upload/8402.pdf

[6] J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf.

[7] General Accounting Office (GAO), "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment" (September 2012), available at: http://www.gao.gov/assets/650/648370.pdf .

[8] Note that public assistance to help pay for Medicare cost sharing is made available through Medicare Savings Programs (MSPs) and the Part D Low-Income Subsidy or Extra Help. Currently, though, full Part A, B and D subsidy protection is provided only for those with incomes up to 100% of FPL, about $11,500 in 2013.

[9] Kaiser Family Foundation, "Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households. An Updated Analysis of Health Care Spending as a Share of Total Household Spending" (March 2012), available at http://www.kff.org/medicare/upload/8171-02.pdf.

[10] J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf.

[11] MedPAC, "A Data Book: Health Care Spending and the Medicare Program" charts 5-6 (June 2012), available at: http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf.

[12] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf.

Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude metaphor, Medicare beneficiaries already have too much "skin in the game," and as a group, are very aware of the high cost of health care services based on the bills they receive and Medicare's summary notice of payment.

Economic and Health Risks Posed by Increasing Medicare Cost Sharing

Cost-Shifting to Beneficiaries Limits Access to Necessary Care

While increased cost-sharing poses significant financial risks for beneficiaries, particularly for those living on low- and moderate-incomes, it is also shown to limit access to necessary health care services. This was a primary finding of the NAIC subgroup convened to explore adding cost-sharing to specific Medigap plans on which our organizations served.

Pursuant to the ACA, the NAIC was directed to "review and revise the standards for benefits in Medigap Plan C and Plan F" and to update those standards to include cost-sharing, if practicable, so as to "encourage the use of appropriate physicians' services…"[13] Toward this end, the NAIC convened the Medigap PPACA (B) Subgroup that included state insurance regulators, insurers and trade associations, consumer advocates and other Medicare experts. This subgroup spent almost two years reviewing available literature on cost-sharing and patient behaviors.[14] In addition, mid-way through its deliberations, the NAIC subgroup issued a discussion paper on more expansive proposals to diminish Medigap coverage and increase Medicare cost-sharing.[15]

The subgroup's research demonstrates that cost-sharing has dubious utility in holding down health care spending and can actually lead to increased total spending on health care when people forego medically necessary services. For example, a major Harvard School of Public Health review of the research on cost-sharing made several conclusions about its utility in controlling health care costs, including: "We do not know if increased patient cost-sharing would reduce the growth in total national health care spending;" "Increased cost-sharing disproportionately shifts financial risk to the very sick;" "Low-income older adults with chronic conditions are at increased risk for poor health outcomes due to increased cost-sharing."[16]

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[13] Patient Protection and Affordable Care Act, §3210.

[14] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" webpage, available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See under heading "Cost-sharing Research and Literature" for summary of much of this literature (as of June 2011) available at: http://www.naic.org/documents/committees_b_senior_issues_110628_summary_dist_research.pdf.

[15] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

[16] Katherine Swartz, "Cost-Sharing: Effects on Spending and Outcomes" (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20, available at: http://www.naic.org/documents/committees_b_senior_issues_110628_rwjf_brief.pdf

In 2008, the CBO similarly determined that a proposal to restrict Medigap coverage of Medicare cost-sharing would lead beneficiaries to face "uncertainty about their out-of-pocket costs." Given this, the CBO further acknowledged that the corresponding "…decline in the use of services by Medigap policyholders (which would generate the federal savings under this option) might lead beneficiaries to forego needed health services and so might adversely affect their health."[17]

Due in large part to these findings, in a letter to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services, the NAIC concluded, "We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost-sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost-sharing be introduced to Plans C and F."[18]

Our organizations strongly support the NAIC's determination. The conclusions drawn by this subgroup are applicable not only to Medigap reform proposals, but also to proposals that would increase beneficiary out-of-pocket costs, such as those under consideration by this committee.

Specific Proposals to Modify Beneficiary Cost-Sharing

Our organizations have been critical of many proposals that would shift costs onto Medicare beneficiaries, including several provisions in the President's FY2014 budget.[19] In its hearing notice, the committee also references other Medicare reform proposals offered by the Bipartisan Policy Center, The Moment of Truth project and the Medicare Payment Advisory Commission (MedPAC).[20] In previous testimony submitted to this committee, our organizations identified the potential consequences to beneficiaries if some of these efforts to redesign Medicare's benefit structure were realized.[21] As outlined below, we are also opposed to the three proposals currently under consideration by this Committee.

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[17] Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

[18] National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

[19] See, e.g., the Center for Medicare Advocacy's Weekly Alert "The Impact of the President's Budget on People Who Depend on Medicare and Social Security" (April 11, 2013), available at: http://www.medicareadvocacy.org/the-impact-of-the-presidents-budget-on-people-who-depend-on-medicare-and-social-security/, and the Medicare Rights Center Press Release, "Statement by Medicare Rights Center President Joe Baker on President Obama's FY2014 Budget" (April 10, 2013), available at: http://www.medicarerights.org/newsroom/pressreleases/2013_11.html.

[20] See Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare and the Health Care Delivery Payment System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf; National Commission on Fiscal Responsibility and Reform, "The Moment of Truth" (December 2010), available at: http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf; The Moment of Truth Project, "A Bipartisan Path Forward to Securing America's Future" (April 2013), available at: http://www.momentoftruthproject.org/sites/default/files/Full%20Plan%20of%20Securing%20America's%20Future.pdf; and the Bipartisan Policy Center, "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment" (April 2013), available at: http://bipartisanpolicy.org/library/report/health-care-cost-containment.

[21] See our previously submitted joint testimony to this subcommittee regarding its February 26, 2013 hearing entitled "Examining Traditional Medicare's Benefit Design." This testimony is available at each of our websites,

- Adding a Copay to the Home Health Benefit

Several Medicare reform proposals include adding cost-sharing or coinsurance to the Medicare home health benefit, which currently is not subject to beneficiary cost-sharing. Starting in 2017, the President's FY2014 Proposed Budget would create a home health co-payment of $100 per 60-day home health episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay.

Imposing such co-pays would have a staggering impact on individuals with long-term and chronic conditions, who, under the President's proposal, would essentially incur $600 in new out-of-pocket costs annually. Additionally, adding copayments to the home health benefit would likely lead to higher hospitalizations (and thus higher costs) as a result of beneficiaries forgoing needed care when they cannot afford the co-payments.[22]

Both the President's and MedPAC's proposals would implement a co-pay only for those who receive home health care that is **not** preceded by a hospital or nursing home stay. While this limitation might seem like an attempt to mitigate the harm of home health copays, instead it would create a perverse incentive toward hospitalization or nursing home care, and would harm people with long-term or chronic conditions. In our experience serving Medicare beneficiaries, we find that many home health agencies are already reluctant to take on patients who need home health for the long haul; further segmenting out the home health population by only charging copays from those who more likely need care due to chronic conditions, rather than those who have short-term post-acute needs, will significantly exacerbate this problem given the reluctance on the part of home health providers to collect copayments (or take on patients who are required to pay them).

In short, we are opposed to imposing home health copays. The Congressional Budget Office estimates that this home health copay would save only $730 million over ten years. This minor savings simply does not justify the great harm it would cause to vulnerable older, disabled people, and their families.

We also oppose efforts to cap Medicare payment based upon episodes of care, either by individual beneficiary or by an individual home health agency's aggregate episodes of care,

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including: http://cahealthadvocates.org/_pdf/advocacy/2013/Medicare_Redesign_Testimony_CHA_CMA_MR_20022513.pdf.

[22] See, e.g., a study in the *New England Journal of Medicine* which found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes and greater expense. Trivedi, Amal N., Husein Moloo and Vincent Mor, "Increased Ambulatory Copayments and Hospitalizations among the Elderly," *New England Journal of Medicine*, January 2010. Also see, e.g., the Urban Institute's Health Policy Center finding that home health copays "…would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays." Urban Institute Health Policy Center, "A Preliminary Examination of Key Differences in Medicare Savings Bills," July 13, 1997.

which would effectively limit the duration of time individuals could access home health services.[23]

- Increasing the Annual Part B Deductible

Several Medicare reform or deficit reduction proposals include provisions that would either increase the Medicare Part B deductible alone or in combination with altering the Part A deductible.[24] Combining the A and B deductible by effectively increasing the Part B deductible ($147 in 2013) and lowering the Part A deductible ($1,184 in 2013) to form a combined deductible somewhere in between these figures would arguably have some benefit for a relatively small number of Medicare beneficiaries who use inpatient services.[25] Merely increasing the Part B deductible for everyone without lowering any other expenses, however, simply amounts to an unwarranted shift of additional costs onto Medicare beneficiaries.

The President's FY 2014 Budget proposes to increase the Part B deductible for newly eligible beneficiaries by $25 dollars in the years 2017, 2019 and 2021, raising the deductible for each cohort of beneficiaries entering the program each of those years. Since individuals currently entering the Medicare program would not face these increased amounts, the result would be four different cohorts of Medicare beneficiaries paying four different deductible amounts. This proposal would increase Medicare's complexity by drawing an arbitrary line between current beneficiaries and near retirees who would be unaffected and those who will join Medicare in the future and will permanently pay more.

Even more worrisome, however, is the impact that an increased deductible would likely have on Medicare beneficiaries, particularly those who are lower income and unable to afford additional health costs. Additional upfront costs in the form of a higher deductible would lead to self-rationing of care as many individuals would postpone needed care which, in turn, could result in increased costs when an untreated illness becomes more complicated and more costly to treat.

- Further Income-Relating Premiums for Parts B and D

The President's FY 2014 Budget proposes to increase income-related premiums for Parts B and D. Medicare beneficiaries with incomes above $85,000 ($170,000 for a couple) already pay higher Part B premiums due to a provision in the Medicare Modernization Act of 2003 (in 2013, adding between $146.90 and $335.70 to premium costs per month, depending upon income). The

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[23] Such episodic payment caps would disproportionately harm individuals with chronic conditions, including people with conditions such as traumatic brain and spinal cord injuries, Alzheimer's, Parkinson's disease, MS, and other such illnesses and disabilities. This is contrary to the recently settled national class action lawsuit, *Jimmo vs. Sebelius*. No. 5:11-CV-17 (D. VT, October 16, 2012). Further, such payment caps would thwart current broad efforts aimed at favoring community-based living as opposed to institutionalization of individuals.

[24] For an analysis of the potential impact of a combined Part A/B deductible, see, e.g., our previously submitted joint testimony to this subcommittee regarding its February 26, 2013 hearing entitled "Examining Traditional Medicare's Benefit Design." This testimony is available at each of our websites, including: http://cahealthadvocates.org/_pdf/advocacy/2013/Medicare_Redesign_Testimony_CHA_CMA_MR_20022513.pdf.

[25] See, e.g., Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011) available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8256.pdf.

Affordable Care Act of 2010 required higher-income individuals to also start paying higher Part D premiums in 2011 (in 2013, adding between $11.60 and $66.60 per month, depending upon income) and froze the income limits ($85,000 individual/$170,000 couple) through 2019 so that each year more people will be subject to higher premiums for Parts B and D.

Today, income-related premiums affect roughly 5% of Medicare beneficiaries.[26] Under current law, income thresholds for higher premiums are frozen until 2019, meaning they are not indexed to increase annually. At that time, it is estimated that approximately 10% of Medicare beneficiaries will have incomes above this threshold and will be subject to higher premiums.[27] If higher premiums were applied to Medicare beneficiaries with the top 10% of income today, it would affect people earning approximately $63,000.[28]

The President's proposal would increase the share of Part B expenses paid in premiums by higher income beneficiaries to between 40% and 90% of such expense, depending upon an individual's income bracket. There currently are four different income brackets with respect to means testing; under the President's proposal, there would be nine income brackets[29], further complicating, rather than simplifying, the payment of premiums specifically and the Medicare program more generally.

The President's proposal would also freeze income-related premium thresholds under Parts B and D until 25% of beneficiaries are subject to these premiums. According to the Kaiser Family Foundation, if such a proposal were implemented today, this would affect individuals with income equivalent to $47,000 for an individual and $94,000 for a couple.[30] In other words, individuals earning only about half of the current income threshold of $85,000 would be impacted by such a proposal. This is an income level, we note, that is substantially lower than the thresholds often used to define higher-income individuals in other policy discussions, including discussions about tax policy.

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[26] According to the Kaiser Family Foundation, in 2012, 5.1% of Part B enrollees (2.4 million beneficiaries) to pay the income-related Part B premiums were estimated to pay the income-related premium. See "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" Kaiser Family Foundation, February 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf.

[27] The share of Medicare beneficiaries required to pay the income-related Part B premium is projected to rise to 9.7% in 2019 (5.5 million beneficiaries). Once income thresholds begin to rise with inflation again in 2020, this number is projected to fall back to 6.6% of beneficiaries. See "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" Kaiser Family Foundation, February 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf .

[28] According to Urban Institute/Kaiser Family Foundation analysis in 2011, the 90th percentile of income among Medicare beneficiaries in 2010 was $63,251. See "Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?" Kaiser Family Foundation, June 2011, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8172.pdf.

[29] "AP Newsbreak: Medicare Means Test Plan Detailed" by Ricardo Alonso-Zaldivar, Associated Press, April 12, 2013.

[30] "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" Kaiser Family Foundation, February 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf .

Our organizations are opposed to further income-relating (means testing) Medicare premiums. Further means testing would undermine the integrity and universality of the Medicare program. Medicare remains an immensely popular program. However, additional means testing would further undermine the social insurance nature of Medicare and could ultimately raise costs for middle and lower-income individuals who rely on it. As noted by the Kaiser Family Foundation, "there is a possibility that proposals [to further means test Medicare] could lead some higher-income beneficiaries to drop out of Medicare Part B and self-insure, which could result in higher premiums for all others who remain on Medicare …"[31]

Conclusion

Our organizations recognize the need to bring down the nation's deficit and reduce health care spending system-wide. We support Medicare savings mechanisms that eliminate wasteful spending and build on the efficiencies of the Affordable Care Act (ACA). At a time when Medicare spending is growing at historically low rates, and innovations through the ACA hold considerable promise of continuing to keep costs down, we oppose implementing unwise policies that seek federal savings by way of cost-shifting on the backs of Medicare beneficiaries.

Under the proposed cost-sharing reforms being considered by this committee, too many Medicare beneficiaries would lose access to affordable coverage, and too many would be discouraged from seeking needed health care services. In short, these proposals threaten the health and economic security of people with Medicare.

Instead of shifting additional costs onto beneficiaries, we support prudent cost containment designed to solve the true threat to our nation's fiscal health: rising health care costs system-wide. To realize this goal, we endorse cost-saving solutions that eliminate wasteful spending and promote the delivery of high value care—meaning better quality at a lower price. Proposals our organizations support include:

Reduction of wasteful spending on drugs, medical equipment and private health plans: Significant cost savings can be achieved by allowing the Medicare program to secure lower prices on pharmaceutical drugs. Congress should expand the tools available to the federal government to achieve this end, including restoring Medicare drug rebates, allowing the federal government to directly negotiate with pharmaceutical companies and introducing a public drug benefit in Medicare.

In addition, Congress should expand the cost savings already achieved by the Centers for Medicare & Medicaid Services (CMS) through the successful competitive bidding demonstration for durable medical equipment. Expansion of the competitive bidding on a national scale should be accelerated and extended to other types of medical equipment, such as lab tests and advanced imaging services.

[31] "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" Kaiser Family Foundation, February 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf .

The ACA took major strides to reduce sizable overpayments to Medicare Advantage. More should be done to equalize payments between Traditional Medicare and private Medicare plans. Private plans should be reimbursed no more than Traditional Medicare.

Advance Medicare delivery system reforms made possible by health reform:
The ACA includes many opportunities to test delivery system reforms designed to enhance health care quality while simultaneously driving down the cost of care. These reforms are meant to improve care quality by promoting better coordination among providers, patients and caregivers to prevent harmful drug interactions, unnecessary hospitalizations and more.

Congress should maximize the Administration's authority to test these reforms in a timely manner. At the same time, Congress should avoid dramatically altering Medicare benefits, so as to allow time for these advancements to yield results, meaning both improved care coordination and better cost-effectiveness.

We look forward to working with the Committee and members of Congress to examine additional cost-saving options in the Medicare program that simultaneously address the systemic issue of rising health care costs that concern not only Medicare, but also to the private health insurance market. We implore you to reject proposals that fail to address this systemic issue and instead achieve only short-term savings by shifting costs to people with Medicare. As such, we ask that you carefully weigh the significant risks posed to Medicare beneficiaries by the proposals discussed above and we urge you to steer clear of these models.

We appreciate this opportunity to submit these comments.

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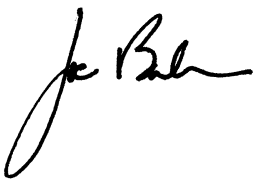

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